

COMMISSION ON THE PROBLEMS OF MENTALLY RETARDED, HANDICAPPED  
AND GIFTED CHILDREN

February 10, 1960

The meeting of the Commission on the Problems of Mentally Retarded, Handicapped and Gifted Children was held Wednesday, February 10th, 1960, in the conference room at the State School and Hospital at Faribault at 9:30 A.M. The afternoon meeting consisted of a tour of the Faribault State School and Hospital by the Commission members.

Chairman Warnke called the Commission to order and the following members were present:

SENATORS

Ray George Child  
Walter J. Franz  
Clifford Uckelberg

REPRESENTATIVES

Moppy Anderson  
Ernest Beedle  
Curtis E. Warnke

Absent: Senator Karl F. Grittner and Senator Stanley W. Holmquist, Representative Lawrence P. Cunningham and Representative George Wangensteen.

Also present at the meeting were Senator A. O. Sundet; Representative R. C. Kucera; Dr. E. J. Engberg, Superintendent; Dr. Thorsten Smith, Clinical Director; Mr. C. M. Henderson, Superintendent of Owatonna State School; Mr. Knack, Principal of the Faribault School; Mr. Oye of Wood Lake and Miss Frances Coakley, Supervisor of Mental Deficiency and Epilepsy of the Minnesota Department of Welfare. Speakers: Mr. Jerry Walsh and Mr. Ove Wangensteen.

The meeting was called to order by Chairman Warnke. Mr. Anderson made a motion that the minutes of the previous meeting be approved as prepared by the clerk. Seconded by Mr. Beedle. Motion carried.

Representative Warnke read the letter from Dr. E. J. Engberg regarding the Grandview Cottage to the Committee as follows:

January 5th, 1960

As requested in your letter of the 5th, we are submitting the following information regarding Grandview Cottage.

This cottage was erected in 1914 for the purpose of establishing a farm colony for boys. The building is of frame construction, with stucco exterior and a slate roof. There is a concrete slab over the boiler room area.

This unit has two dormitories on the first floor, each accommodating 28 beds and one dormitory on the second floor accommodating 14. There is a two room apartment for the charge aide on the first floor and four single rooms for

employees on the second floor. There is also a day room for patients in the basement, as well as a clothing room on the first floor; other storage is dispersed in other areas of the cottage.

This cottage has its own kitchen for preparing meals and has dining rooms for patients and employees. Two deep wells furnish the water supply, with a septic tank arrangement for sewage disposal. Heating is by a coal fired boiler, stoker fed. A sprinkler system is being installed at the present time. Raw foods, supplies and laundry service is supplied from the main campus.

The present staffing consists of 1½ Cook II, 1 Psychiatric Aide II, and 5 Psychiatric Aide I, with relief personnel furnished from the main campus in case of emergency or prolonged illness.

The electrical power supply for this unit is furnished by the Steele-Waseca Co-operative Electric Co. (R.E.A.).

The cottage is located approximately five miles from the main institution campus. It is located in a rural area and because of its location it presents not only a serious fire hazard especially during the winter months when roads may become blocked with snow, but it is also an inefficient unit to operate because of the distance from the main campus.

The present population is made up of 70 elderly, ambulant males. Our recommendations to the Legislative Building Commission included the replacement of this building in 1961."

SENATOR CHILD: How do they prepare their food out there?

DR. ENGBERG: They prepare their own food - baking goods are taken in from here.

SENATOR CHILD: There is danger of fire.

DR. ENGBERG: Yes. The danger now even with the sprinkler system if fire did occur and they had to vacate there is no place to bring them quickly since there is no buildings nearby.

SENATOR CHILD: What does the Building Commission say?

DR. ENGBERG: I believe that they are recommending that with one of the new buildings that will replace some of the other older buildings that we plan on incorporating enough beds to take care of them. The patients there are ambulatory but essentially senile.

MR. JERRY WALSH: This is as you know the third general presentation we have made to the Commission. The first was made by John Holahan, the second by me at Cambridge and this is the third. At our first meeting we gave you an outline for suggested areas of study by the Commission. The main headings were - Institutions - Planning for the Non-Institutionalized Retarded - Research - and Division of Mental Retardation Within the Department of Welfare.

We visualize a Division a for Mental Retardation and Epilepsy and have given this considerable thought and have observed this being developed in other parts of the country.

#### I. CENTRALIZATION OF PROGRAM RESPONSIBILITY

First we should like to indicate why we feel program responsibility for the mentally deficient and epileptic should be within one unit of the Department of Public Welfare. The law places general responsibility for the welfare of the retarded upon the Commissioner. It is our belief that unless the same unit within the Department is responsible for all program activities there will be a less adequate program provided and that either the duplication or omission of some needed service will be found.

Viewing the state program from our standpoint we see the following elements as composing it:

A community program - Guardianship	
	Counseling
	Education of public
	Private residential facilities
	Day-time facilities and recreation
	Clinics
	Psychological Services
An Institution	
Program -	Program of care, training and education
	Placement in community
	Community education
	Clinics (if established)

It is our belief that all these services should be administered as one program. There are of course certain financial aids to which the mentally retarded may be entitled, but the determination of eligibility and payment of aids would naturally rest elsewhere. However individual program planning or case work services as may be needed would be the responsibility of the overall unit through direction of the county welfare boards, of course.

Another reason for all program planning for the retarded being located in the same unity is that Minnesota has an inter-agency committee on mental retardation. The inter-agency committee has representatives from the Departments of Health, Education and Welfare and the Executive Director of the Minnesota ARC. This is not a policy making body, but it would seem there should be one person who speaks for the commissioner when discussing policies with other agencies. This is true even though his authority may be delegated to section heads in discussing plans with the other departments.

Minnesota also has an advisory committee on the handicapped authorized by the legislature. It is of interest that inter-agency or inter-departmental committees of some type are now recommended to the states by the council of State Governments. Also almost every state commission on mental retardation whose reports have so far been received by the Minnesota ARC has recommended such a body.

## II. DIVISION FOR MENTAL RETARDATION AND EPILEPSY.

Now I would like to comment on some reasons for a separate division within the Department:

1. The problems involved are sufficiently complicated and broad and the numbers included sufficiently large to warrant a separate administrative unit.

The mentally retarded range from infants to very old persons; in intelligence level they range from the lowest to those almost able to "make the grade" alone; in physical, social, emotional, financial and educational status and needs there is the same broad range. Thus work with the retarded stretches into practically every field concerned with providing services for individuals and there must be cooperation with a great number of public and private agencies.

The National Association for Retarded Children after a study indicates that 3% of the population is sufficiently low mentally to be in need of some special type of service and there is general agreement with this estimate. I have here a booklet that Dr. Engberg gave me put out by a group for advancement of psychiatry and they use also the same 3% figure. The New York State Joint Legislative Committee on Mental Retardation in its 1958 report makes this statement: "The large number of persons mentally retarded far exceed all other handicapped groups." We have written for this report, but have not received it. We have however, seen a statement made by a member of the New York ARC that the 1959 legislature passed a law setting up a separate unit for the retarded within the State Department of Mental Hygiene.

2. A person with administrative experience, broad knowledge of all phases of mental deficiency and the highest ability will be required to administer this total program.

The Director of a Division of Mental Retardation and Epilepsy should be a person who has had experience with the mentally retarded and who in ability and preparation in his own field would be on a par with a person holding a similar position in the field of mental illness.

3. The mentally retarded and the mentally ill do not present identical problems.

When the two groups are included in the same program, our observation has been that there is a tendency for the program to be made to fit the mentally ill, and then the mentally retarded must fit into it - that is they simply "tag-a-long".

As an example of this attitude, I am outlining one action which I believe was done unconsciously by Minnesota's Director of the Division of Medical Services. A classification of institution patients was made in order to determine the needed number of psychiatric aids. Your attention was called to this in a previous presentation and the fact that after trying for some two years, I believe, to fit the retarded into the phrasing of the described categories, before leaving the state Dr. Cameron recommended that the super-

intendents of the institutions for the mentally retarded consider this wording and change it to fit their own categories. This is a small example, but we believe it is the kind of thing that happens frequently when the mentally retarded become just an item in an overall mental health program.

I personally have had a feeling that when we speak of mental health we should not tend to include the retarded. If you ever have picked up a booklet on mental health you will find that it is almost always on mental illness and it is very seldom that a booklet on mental health will include anything about the mentally retarded. We are talking about separate categories and separate programs.

SENATOR CHILD: In that last part I do not understand just what you are recommending.

MR. WALSH: The present categories that have been set up for deciding on staffing, the retarded or mentally ill are divided into three groups, 1, 2 and 3, with Group 1 being the least able and Groups 3 the most able, and each of these groupings were described, phraseology, and this phraseology did not fit the mentally retarded because their problems are so different. It has been difficult to try and say well now this is the group of retarded that fits in the group so therefore they should have so many psychiatric aids. We still will maintain the groups 1, 2 and 3 but we will rephrase the description.

SENATOR CHILD: Because of this inadequate phraseology has there been any difference in the number of employees hired.

MR. WALSH: I think the thing that we have noticed because of the difference of phraseology is that the descriptions have been interpreted differently by different institution heads and therefore they all plan differently.

SENATOR CHILD: There is no uniformity.

MR. WALSH: A review of what is happening in some other states indicates the same problem is encountered elsewhere.

In trying to understand why the mentally ill get more attention, there seem several possible reasons:

- a. All socially non-conforming persons were once thought of as insane, now mentally ill. The mentally retarded concept is relatively new to the public.
- b. Any one of us may become mentally ill.
- c. Mentally ill persons are usually basically competent and may be restored to competency - that is they need treatment for possible recovery. For the mentally retarded there is not recovery to look forward to.

In comparing the programs for the mentally ill and the mentally retarded we are struck by the following: The number of infants and children who are retarded differentiates this program markedly from that of the mentally ill; the mentally ill program emphasizes treatment to get well. The mentally retarded will not get well, but must have in addition to medical care, train-

ing and education to help them fit into life even though still retarded. The emphasis is markedly different.

4. There is a nation wide trend in the direction of a separate administrative agency because of the great and growing interest in the retarded.

Some examples of the above statement follow. Our association has requested reports from all states known to have or to have recently had study commissions on mental retardation, but few states have sent these as yet. We hope therefore to have more information on the plans of other states at a later date. First a recommendation from an interstate agency.

The Council of State Governments:

This is from their Report and Recommendations of the Conference on Mental Retardation November 20-21, 1958. Interstate clearing house on Mental Health.

On page 2 there is the following statement:

"Such departments as education, mental health, health, welfare, labor, corrections, and institutions of higher education offer programs and services for the mentally retarded. Within a given state there may be other departments concerned with the mentally retarded. Within each of these departments, there should be a division or bureau for services to the mentally retarded or a special consultant with specific responsibility for the development and administration of these services."

The December 1959 issue of Children Limited, the paper of the National Association for Retarded Children had reports from state ARC groups. Two Associations reported their states now have special units for the retarded within an overall state department (most institutions and overall programs are in a Department of Public Welfare, (Department of Mental Hygiene or Mental Health or a Department of Health). The two reported are:

New York - Office of Mental Retardation, established in the Department of Mental Hygiene with a Deputy Commissioner and an Assistant Deputy in charge. (An act passed by the 1958 legislature). A further comment on this development in New York is made by Dr. Stanley P. Davies in a study of the Mentally Retarded made for the New York State Association for Mental Health in the fall of 1959. On page 55 of this report, Dr. Davies speaks of the significance of the appointment of the Commissioner of mental hygiene to the office of Deputy Commissioner of a man thoroughly qualified to administer the program. He then indicated responsibility as follows:

"In addition to direct responsibility for the administration and development of the state schools for the mentally retarded, the Commissioner and the department are in a strategic position with respect to clinical and other community services, through the charge laid upon the Commissioner in the State Mental Hygiene Law to supervise, regulate, and give direction to the development and rendering of community mental health services under county and city mental health boards.

Connecticut - A Division on Mental Retardation, established in the State Health Department with a Deputy Commissioner in charge (law passed by the 1959 legislature).

The Division has jurisdiction over institutions, community programs - everything but public schools and vocational rehabilitation.

We have now some recommendations from state commissions which have studied the problems of the retarded.

New Jersey: THE STATE'S ORGANIZATION FOR SOCIAL WELFARE is a report of a citizen's commission to study the Department of Institutions and agencies appointed by the governor and financed by the Rockefeller fund. It reported in 1959. On page 23 we find the following:

"The Bureau of mental deficiency is now operated virtually as a separate Division. It would seem wise either to recognize the defacto situation by making the Bureau a division, or to determine that the defacto situation has been permitted to develop in error. We strongly urge the State Board to take early action on this matter. Our Commission favors creation of the new division."

Illinois: REPORT OF THE COMMISSION TO STUDY MENTAL RETARDATION

The general commission appointed by the Governor in 1959 with representatives of the Assembly and public and private agencies. The report was made on 12-22-58. Recommendation I, Page 3 is as follows:

"It is recommended that a Division of mental retardation with funds to implement an adequate program be established within the Illinois Department of Public Welfare. The purpose of this division would be to:

'Coordinate the services of the Department of Public Welfare to the state's mentally retarded citizens.

'Focus attention on the problem of mental retardation, as distinguished from the problem of mental illness.

'Carry out the recommendations of this commission as related to the Department of Public Welfare."

Indiana: Report of Legislative Study Committee on Mental Retardation. This committee failed to make recommendations other than that the committee be continued. However with its report on its study of the problem it included a memo of recommendations from the St. Joseph County Council for Retarded Children - December 10, 1959. On page 2 of this memo there is a list of recommendations. One of them is as follows:

"Create an office of State Commissioner on Mental Retardation with regional (county) commissioner under him. The State commissioner would be responsible to the Governor and a committee composed of representatives from the State Board of Health, Department of Public Welfare, Department of Public Instruction, the Division of Mental Health, and the Indiana Association for Retarded Children, Inc."

This type of centralization is not what the Minnesota Association recommends, but it is quoted to show the extent of thinking along this line.

Oregon: REPORT OF LEGISLATIVE INTERIM COMMITTEE ON MENTAL RETARDATION AND EMOTIONAL DISTURBANCE, October, 1958.

A bill was drawn for the establishment of an Inter-departmental Board of Health, Education and Welfare, with considerable responsibility for recommending changes (bill begins on Page 89). One reason for this Board was given "There exists a need for a fundamental re-evaluation of the organization of agencies administering Health, Education and Welfare and other social services at the state level." This may not automatically mean a coordinated program under one head in each department, but since the organization is to be re-evaluated, this may happen.

We hope to have other reports soon. Certainly the trend throughout the country is to re-evaluate programs for the mentally retarded in order to make sure their needs are met adequately, and in the most effective manner. We believe that in Minnesota this could best be accomplished by a Division on Mental Retardation and Epilepsy which would include all programs or licensing and supervising of programs for these groups.

Those are our comments on a Division. As I say, it is something that we have observed for a number of years and is the type of program we feel would be beneficial to the retarded.

MR. OVE WANGENSTEEN, Deputy Director, Department of Welfare. Mr. Chairman the matter of organization of any State Department is, of course, one that can be disputed one way or the other. Commissioner Hursh wanted very much to be here this morning but two other commitments prevented him from coming. We had discussed in the central office this matter and Mr. Hursh is aware of this. It is true that centralization of program responsibility is one thing that we are very much interested in and I suppose in the State Department of Public Welfare it is possible for us to set up many more divisions within our Department than we presently have. However, at the present time the Commissioner has reporting directly to him five separate already established Divisions within the Department as well as a personnel officer, myself as Deputy Commissioner, and other auxiliary services. This comes to the question of span of control in terms of basic organization as to what any one person can reasonably be assumed to handle. This matter of a great many persons reporting to him might be detrimental to the program. Maybe he would not have time along with his other administrative responsibilities to spend as much time on any further divisions within our Department than he now does. That is a basic problem in administration which I suppose can be disputed and argued one way and the other, but just the basic problem of span of control for a person in one office is a great deal of responsibility.

Many things that Jerry has mentioned is very, very interesting and certainly bear further discussion and thought. I suppose basically the establishment of another division would not throw our organization too far out of line, but along with this, of course, comes interests of other groups concerned about the problems of people and their need too to want additional divisions within the Department created, and functionally we get to the point where we categorize people of every minute problem that they may have. They might be building up an empire that would be extremely difficult to administer. I don't think that I am qualified to dispute any of the things that Jerry has presented. I think some of them are very good. It is true that mental retardation is different than mental illness. Mental retardation, as far as the central office is concerned, we feel there are social ramifications, there are medical ramifications, and both require a great deal of attention. Now the Commissioner does have responsibility for all the institutions, the hospitals in the State and one of the administrative devices presently employed is an organization or a supervisory group of the State Superintendents of the Hospitals and Schools getting together regularly once a month to discuss mutual problems. The establishment of a separate division of retarded and epileptic could possibly interfere with this as institutional management often time bear similar administrative problems, and it is possible for this group working together to benefit from experiences one upon the other. For instance, one of the projects at the Hastings State Hospital is being considered by Dr. Engberg, Dr. Atkins and Mr. Peterson. They think this might work - they have been using this device and they think this might work. They have been using this device with the mentally ill and they think that there is a possibility that this can be a very fine thing in treating mentally retarded persons too, so there is an interplay of information between the superintendents of all the hospitals which we feel is very, very valuable.

I think in terms of the differences, that Jerry has mentioned, of classifications between institutions that this is really an academic thing. I think there are differences in our classifications of mentally ill persons too that are not totally agreed upon by different psychiatrists and whether or not the establishment of a hard and fast classification of patients is necessary, I don't know. There is, of course, the mentally ill, the minute diagnoses, some are accepted by some psychiatrists and not by others. I think this is also true of the mentally retarded. It is pretty hard to take a person who might fall right in the middle and place him one way or the other. This really is a matter of individual interpretation by the person who has the knowledge of that individual person.

Concerning the Bureau and definitions you mentioned in other states. I think all state governments have minute differences and organizations and to use the information you presented in its entirety we would have to study the whole of that individual state government to find out why this particular bureau or division was established and its relationship to other state departments. Then we feel very strongly, the Department of Public Welfare, and I always emphasize this because this has been my experience that the

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Department's relationship with the County Welfare Boards are the most valuable thing we have. The State Department of Public Welfare by law as it relates to the County Welfare Boards is the supervisory agency. The County Welfare Boards are locally administered but are supervised by the State Department of Welfare. This, of course, is a very valuable asset to the central office of the Department. Our relationship with the County Welfare Boards would probably not be severed, not even disturbed, if we created a separate division of mental retardation, but there is emphasis in the Section of Mentally Deficient and Epileptic on the County Welfare Board. When I first started as a case worker in western Minnesota, one of our programs, along with all the other responsibilities of the County Welfare Board was that of the mentally deficient and epileptic and I felt at that time, and Miss Coakley knows this, that actually this really basic organization which we had then and which we now have emphasized this program. Many counties, and Meeker County where I was employed, had a very small case load of mentally deficient and epileptic, but program wise the County Welfare Board spent a disproportionate amount of its time on this particular program. This has been very good. The Section on Mentally Retarded and Epileptic in the State Department of Public Welfare has been a strong section with far reaching influence to the County Welfare Boards where most of the case work services are actually being provided.

The coordination of services between the State Departments is quite well handled. Our relationship with the Department of Education has been very good. The coordination of the Mentally Retarded and Epileptic with the Department of Education has been as far as I know quite satisfactory. The focusing of attention on problems of mental retardation as distinguished from mental illness is something that I have been under the impression has always been quite strong. A separate section within the medical services of the Division for the Mentally Retarded and Epileptic has been a strong section because of strong leadership and they have pretty well stated their case. This has been accepted by the whole Department as a real coordination of services for the people in Minnesota. I would be very glad to try to answer additional questions when they come up. Basically we would like to strengthen all services to people for which the Department of Public Welfare has a responsibility. How best to achieve this in an organization in an administrative manner can be discussed from now until dooms day and there will always be two points of thought. We very much appreciate the efforts that Jerry's group has put on this and it will guide us in our thinking too. We are not closing the door on it by any means. We have some pretty strong convictions concerning our present organization but any organization that is static of course is not progressing and these things, of course, will be seriously considered and it might be that changes in organization, whether it be the establishment of a separate division or not will be made. Miss Coakley is here and has had far greater experience than I in this field.

SENATOR CHILD: Have you figures on what the additional cost would be?

MR. WALSH: I don't think so. There is a position authorized for an assistant to the Director of Medical Services to handle the work but that position has not been filled but the appropriation has been made. It would be filled by pulling in people who are already working in other sections into this section. For instance there is one man who deals exclusively with licensing of facilities for the retarded. He works with day care centers, residential type of business or homes, etc. He has to do with licensing and also the type of program that is carried on in this particular type of private facility. It would be the matter of bringing a person like this into the Division. There would be some additional personnel.

MR. WANGENSTEEN: This again becomes the question of basic organization. For instance, we have within the Child Welfare Division a Section on Standards and Licensing. We have one man responsible for licensing institutions for the retarded. They have other people there who have responsibility for licensing centers for other children. They also license boarding homes. The County Welfare Board recruit and recommend licensure. These boarding homes often times are used for both, it might be for a retarded child or it might be for a neglected child. There is no basic difference for licensures. It again depends on your basic concept concerning organization functional approach versus self contained, providing total services. This is true in our fiscal or administrative services division which has responsibility for statistical, accounting reporting, procedures, etc. I suppose theoretically this could be contained within a smaller, broken down, and provided within all the sections but I don't think this would be economical in terms of total operation. We, of course, have very much diversified information going to all our sections whether it be on the old age assistance program or the program for the mentally ill or mentally retarded. It is all contained in one broad administrative services section. It provides information to all the divisions within the Department.

MR. WARNKE: I notice in this statement on the Council of State Governments it says -

"Within each of these departments, there should be a division or bureau for services to the mentally retarded or a special consultant with specific responsibility for the development and administration of these services."

Your recommendation is more for the Division?

MR. WALSH: Yes.

MR. WARNKE: Have you given any thought to the special consultant type?

MR. WALSH: Actually we have a number of special consultants within the Section - we have Ben Reuben who is a consultant on community services to the retarded and Francis Coakley who is certainly in many of her responsibilities would be to consult with people who have problems in mental retardation within the County Welfare Boards and other places - we do have consultants.

MR. ANDERSON: I am not familiar with the program for the epileptic. What treatment do they get in the hospitals, is there a cure for them and are they making progress in this particular field?

MR. WANGENSTEEN: There is an evolutionary reason why retarded and epileptic go together. Miss Coakley will answer that.

MISS COAKLEY: In answer to your question there has been great progress in the field of epilepsy so that actually through the development of better medicine and treatment the largest number of the epileptic may remain in the community and there is no need for a commitment in epilepsy or use of any institutional facility for their care. It is only in a very small number of epileptics that would require guardianship and who would require institutional treatment. They are now being placed in our institutions for mentally retarded where the medical staff is providing the medical treatment along with the social treatment and therapy and we hope that eventually they might return to the community. It is a very small number.

MR. ANDERSON: One more question - can they be cured?

MISS COAKLEY: I would think that they could. Dr. Engberg and Dr. Smith might be more competent to respond to that. I would certainly expect a pretty good chance of success.

DR. ENGBERG: I think that one thing we have to keep in mind here and that is if we speak about epilepsy from a medical standpoint we are thinking about idiopathic epilepsy. There are a good many patients who are seen where the public would look upon them as epileptic but where the condition may be some other condition - a brain tumor or some local condition in the brain can be causing the convulsive attack so that basically one has to be sure of your diagnosis. If it is what we call idiopathic epilepsy which means that as far as we know no organic condition is responsible for it, most of those cases under present treatment respond very favorably. In the group that does not respond will be a large number who are also mentally defective so that the commitment might be either mentally defective or epileptic. There are others where you have behavior disorders. These are the unusual cases where we are having what we call an epileptic equivalent, instead of just the normal convulsive attack there is a change in behavior that might be a very dangerous type of behavior. Those are the exceptional cases. They are the type of cases under the present commitment that would come to us and would be the kind that would require very careful psychiatric study and where your responsive treatment many times is not very good.

MR. WANGENSTEEN: I understand the percentage of the epileptic is very small.

DR. ENGBERG: Very small requiring institutional care. If they are in it is because they are mentally defective in addition to being epileptic or present serious behavior disorders.

MR. WANGENSTEEN: May I illustrate Mr. Anderson's question. Before I left the County Welfare Department we made arrangements for returning two epileptic women who had been in institutions, one for 40 years and one for in excess of 20 years. Why they were in the institutions that long it is hard to explain, but you see that even that long term hospitalization they still returned to the community and as far as I know they made a satisfactory adjustment.

SENATOR CHILD: In connection with this proposal - presently are the retarded kept somewhat separate from the mentally ill within these institutions or are they thrown together?

MR. WANGENSTEEN: There are two commitments, one in mental illness and one in mental retardation. Faribault, Cambridge and Brainard are for the retarded and epileptic, the others are for the mentally ill. There are times when a mentally retarded person can become mentally ill too. They are kept pretty much separated.

DR. ENGBERG: I might explain as far as Faribault is concerned, we do have some patients that we look upon them as mentally ill. They are the so-called childhood schizophrenic patient that are mentally ill but are ordinarily handled as mentally retarded and those patients as we have them are with other patients. The epileptic is also with the mentally retarded so there is no segregation. I think that is the question you are asking. Segregation from those who are mentally retarded. The ones that we have are not the mentally ill type that ordinarily are regarded as such, the ones with delusions. These are behavior disorders and it is that class of individual. Many times there is a very very difficult differential diagnosis to make in these particular cases. Are they mentally ill, that is a childhood schizophrenic, are they emotionally disturbed - it takes a long time of observation by a very competent person to make a differential diagnosis between those conditions.

MISS COARLEY: There are several comments that I would like to make essentially reporting Mr. Wangenstein's views on this. On the report presented I would like to refer to the first page in relationship to "Program Responsibility". I think there is no question but what the Minnesota Association for Retarded Children would include good research, both in community programming and institution programming as a vital part of any program in mental retardation. This research would be in the area of prevention as well as in the areas of diagnosis, treatment, therapy and anything that might help to bring about better treatment for the retarded. I would put emphasis on research in the community programs just as strongly as an institutional program.

I have a feeling that these of us who are working in mental retardation have been able to profit a great deal from the knowledge and skills of allied fields, referring not only to the mentally ill, the whole psychiatric field,

but also to the total welfare field. Although any one of us in a program for retardation hope that we will build and develop a very strong program in our field, I believe that we see the desirability of spreading our knowledge and our skills to as wide a group of people as possible. Since Minnesota's program for the mentally retarded is socially based going back to the guardianship law of 1917, and since we are working in the local communities through our County Welfare Department, it is important that we disseminate as widely as possible information and skills about mental retardation. This is what we are trying to do with our present organization in the Department of Public Welfare. I think, too, in terms of staffing it is important to remember that in all of our professional fields we have a shortage of trained professional personnel. This means that we must be using those staff professional personnel which is available to us as wisely and economically as possible. This is also what we are trying to do in our Department of Public Welfare through integration of services. I believe that it is possible to integrate services in all the Divisions which exists. This has been our goal and our desire that we in the Section for the Mentally Retarded are trying to work cooperatively and as closely as possible with all the other Divisions in Public Welfare. It seems to me that our goals are very similar to the Association for Retarded Children for building a stronger program for the retarded can be accomplished through integration. I wonder if there is full realization of the responsibility for the section of the Mentally Retarded. Since I have been in the section since last September we have been called upon for responsibilities not only for community programs but a great deal of responsibility relating to the institutions for the mentally retarded has been referred to our section. As Supervisor of the section I have been called upon to pull together trends in the field in the programs for the retarded in Minnesota for the past 10 years, to try to analyze and to see where we are going and how we can improve the total program for the retarded. The fiscal section is constantly referring to our section for material. It seems that the way the program is functioning our section is being looked upon as the group of people who are specialists in this area. We do have our Director of Medical Services and Assistant Director of Medical Services to work through to the Commissioner of Public Welfare.

There is one other thing that I feel that I must say concerning this report. On page 3 - this is the concept of mental retardation that I am a bit concerned about. I think I brought this out at the Cambridge meeting. I should like to refer to the publication Mr. Walsh referred to as just off the press - the publication on mental retardation from the group for "Advancement of Psychiatry". In the ideological factors in mental retardation strong emphasis is placed upon cultural and social factors in mental retardation. This concept, together with a new definition of retardation which has come out from the American Association on Mental Deficiency has real importance in our field in that emphasis is put on social and cultural factors. This to us who are in a social welfare field has real meaning in the strengthening of conditions within our community. The new definition of retardation from the American Association on Mental Deficiency states that the diagnosis may be considered a description of the current level of functioning. This is doing away with some types of mental retardation, the concept of permanency and is giving a more hopeful viewpoint in terms of what we may accomplish

through the increase of our own knowledge, our skills and development of forces within the community. I think this pertains to item No. c. and the following paragraph on page 3. This is an area in which psychiatry has made some contributions in research.

DR. ENGBERG: Could I add a little to this statement. Senator Child raised the question as to segregation. Many of you might feel that there is some differences in the statements made by Mr. Wangenstein and myself. I think that I should explain a little further. Personally I feel that we should put more emphasis on the fact that we are thinking of individuals and not a person who is mentally retarded. That person is subject to all the illnesses that any other person might have, tuberculosis, smallpox, etc. The individual may be committed as mentally ill, goes to an institution for the mentally ill because of a frank mental illness picture and then is found to be mentally retarded. Then the question comes up is it a superimposed condition or is this the result of the mental illness. That individual going back to the community then might be committed and come to us. That individual coming to us then might again develop an attack of mental illness wherein there is delusion with a frank picture of a mental illness. We would not attempt to take care of that patient here ordinarily except for a brief period of time just to be sure that we were not dealing with some spreading brief inter-current type of illness, but we would transfer the patient to a hospital for the mentally ill on a temporary medical transfer and that person would come back to us. In other words, I think we should bring out this fact that there are differences in the types of mental illness so in the case of a young child who is a childhood schizophrenic, that child can be taken care of better here than to go to a hospital for the mentally ill where there are adult patients, but the individual who develops a mental illness here, a frank mental illness where they have delusions, where they are resistive, where they have to be tube fed, naturally can get better attention at a hospital for the mentally ill than we could give here at least at the present time. I just wanted to amplify this because I think you might feel that Mr. Wangenstein and I differ in our opinion - it is more in the type of mental illness that we are discussing.

SENATOR CHILD: As I see it then there is an overlapping.

MR. WALSH: We are not speaking exclusively of people who might be admitted to the state institutions, we are speaking of dividing the program of the mentally ill from that of the mentally retarded. We are thinking of all aspects of the program for the mentally retarded, not just institutional care, schools or anything else. I don't think that anybody would say that there is a considerable problem in separating the retarded from the mentally ill. I think the people who are committed here as retarded are believed to be definitely retarded and sent here for that reason. I don't think that when they sit down too often they say that this child may be mentally ill but he may be mentally retarded. When they make a judgment they are pretty sure that they have made the right judgment. One question that I was going to ask in relation - I certainly agree with Miss Coakley that there are certain cases of mental retardation that may not be considered

permanent cases and these would very often fall perhaps at the higher level. I am going to ask Dr. Engberg - Do you find that you have sent very many patients back to the community once they were here because it was found that they weren't retarded after awhile? Does that happen very often?

DR. ENGBERG: It will happen occasionally but it is not frequently. Occasionally we will have a patient that will come to us, for instance when they use the conference - YCC - that will come to us where there is a question whether the individual is mentally defective or possibly epileptic for study. We make a report and on the basis of the report the decision would be made by the YCC as to what action they would take. It is unusual that we see the case that has come to us as mentally retarded and where we find that that condition is not true. There may be cases that come to us that we feel are on the boarder line and they are the type that Miss Coakley is speaking of especially, where after a period of time here we recommend that they go back to the community and many of those work out very satisfactorily. I think we would all feel that that individual later on could not be regarded as a mentally defective person, but at the time of commitment that one would have to feel that there was a basis for such a thing.

MR. WARNKE: Jerry do you have any idea on the states that you mentioned here in regard to their action, as to whether they made any recommendation in regard to services for the deaf, blind, etc. within the department. Do they also put emphasis on creating separate divisions for each.

MR. WAISH: No. Mental retardation has a problem and is many, many times larger than these other groups. Also these were specific commissions dealing with the retarded. I would like to make a couple of comments on Mr. Wangenstein's proposal. Certainly first we are very willing and in agreement with you that the organization within a Department is an administrative function. We realize this. Also we do not know how many divisions the Commissioner might be able to handle, one, ten or fifteen. We are not of course commenting on that at this time. Certainly there may be other groups dealing with problems which concern many fewer people who would like to have a division. Again we are not aware of this because I think this would be an internal thing. If there are other sections that are bringing pressure on the Commissioner to establish a division I can realize that he may have problems of this kind, but I think they are isolated from this particular problem that we are talking about at this time. I think the main thing that we should do here is not think about how many divisions the Commissioner can handle or what other sections should be, but is this a program that would be beneficial to the retarded. Then we would have to consider it in the light later of what the Commissioner might be able to handle, as far as the number of divisions are concerned.

Also I think it is extremely important that we think of the duties of a Division on Mental Retardation in relation to the program for the retarded as it develops in the State. Realizing that we have made a number of recommendations and you people have a number of thoughts on how the services for the retarded might be improved, for instance, one of our recommendations

is that the state give matching funds to community facilities for the retarded. You can see that this will make considerable larger job out of all of these things in the program for the retarded. There has to be somebody who with more services available can decide what group might be eligible for funds. We are thinking about an expanded program for the retarded which would serve many, many times the number being served at the present time so we should not and cannot think of it, I don't feel, strictly in terms of the program right now.

SENATOR CHILD: I know this has nothing to do with the proposal of your suggestions - didn't they have publicity on a proposal suggested by the Superintendent at Anoka, Dr. Peterson, that the mental health program be divorced from the Welfare Department and set up as a separate department. At that time I was asked by the reporter my reaction and judging from what experience I had had up to this point, my reaction was unfavorable toward the divorcing of the whole mental health program from the Welfare Department. It would sever that most important link between the county organization and the state office. I was just wondering if this program of yours has a tendency to go not quite so far but somewhat in the same direction.

MR. WALSH: It would give better emphasis for the program of the retarded. The superintendents are suggesting a program that they feel would give greater emphasis on what they call the whole mental health picture. You will realize in reading the article that they talk about the mental health program but at no point do they mention the retarded. However, they are thinking of the retarded as part of this, but when they give reasons for a mental health department they give these reasons based on mentally ill only and mental retardation is, I think at least the same, as big a problem as mental illness. We think the problem of mental illness as being larger because we have in our state institutions. But the nature of the problem of mental illness is such that if a person is discovered to be mentally ill it is usually when he needs institutional care. Therefore, we have more in an institution. We say that 1 out of 10 people will be mentally ill. This is 10%. We say that 3% is retarded. However, we are speaking of the amount of 10% throughout their life time so that at any one given time we are not going to have 10% who are mentally ill. We are going to have probably less than are retarded in any one given time. I think that this thing that you mention, a separate department of mental health further emphasizes the fact that when people think of mental health they think of the mentally ill and the mentally retarded are not included in their plans.

MR. VARNKE: I think we should move on and at a future date we may want to take another look. I know that Mr. Hursh has quite strong feelings on the matter and maybe he would want to make a statement.

MR. ANDERSON: What is done when the mentally retarded become ill?

DR. KINGSBERG: Some of this will come later. I think it might be well to make this statement. Here in Minnesota we have separation of the program that ordinarily does not occur in other states. The Owatonna State School has the children who have IQs of 50 or better and who do not present any serious additional handicap. Here we have all types of patients except for those who go to Owatonna. The patients we are receiving now are much more severely handicapped than was true previously, that is those who have other

conditions such as hydrocephalus, cerebral palsy and other genetically determined deficiencies so that all patients as we now receive them require a great deal of nursing care. Many of them are the very helpless type. For instance, at the present time we have 6 or 7 patients, very young children, who have to be tube fed; they can take nothing except by tube. We have a large so-called neurological type of population. Then too they come in with various disabilities, heart-conditions and other physical handicaps. Fortunately the problem of tuberculosis is no longer a prominent one. We have no cases of active tuberculosis in the institution at all. We are subject to the flu, infectious diarrhea, infectious hepatitis - not limited to the patients but including the employees here - and we are having the same experience that institutions nationwide are having whether private hospitals or public institutions of what is called the staphylococcic infection, so we do have a very extensive medical program that is necessary in our population and quite a contrast of what Mr. Henderson would have in his program.

We immunized all of our patients against flu last fall - we thought a long time about it because of the expense but we felt we should do it. This year because of that they feel it has not presented such a serious problem as compared with two years ago. It is a little too early to know the total results but at present it looks as though it will be helpful to us.

MR. HENDERSON: I wanted to make a comment. In the first place this being new to me have not read the arguments for or against it. I think what Jerry is saying is a little more apropos to us for two reasons, one is that we have such different kinds of boys and girls - we are purely a school and we do things quite radically although we have some that go off their rocker a little bit now and then too. Secondly, I am an educator and I don't have the same kind of relationship to the mental health program that say Dr. Engberg does who is a psychiatrist and the other Superintendents being psychiatrist there is a relationship that is much easier and much more understanding. We are a little different.

MR. BEFDLE: I just wanted to make a general statement in regard to what Jerry has said, first of all, it would seem that there is some value in the type of program that he suggests and I don't want him or anyone in this room to get the impression that I am approaching this in a negative manner, but I notice before the answer you gave in regard to the expanded cost was a rather general one and to be sure since the report you gave was preliminary in nature you wouldn't have an opportunity to have complete figures certainly at this time, however, I do know from experience with this type of program that sooner or later if it is found beneficial to the State of Minnesota you are going to run into this problem. I would appreciate if at a later date if more is going to be said along this line that figures be brought down so that we will have them here to look at in the light of the recommendation that we will have to make to the next session of the legislature.

MR. WALSH: I will certainly will do that. I certainly will anticipate in that our recommendations will result in the State of Minnesota spending more money for the retarded. I will make the best estimate that we can.

MR. WALSH: I think all of you have received in the mail our Study which for the most part is an appendix really - the first 15 pages relates to the report.

I think if we go to page 5 skipping some of the preliminary statements - we are talking about specific things we are interested in in this report, the fact that Faribault has inadequate staffing, overcrowding and the need for a long term building program to alleviate overcrowding and eliminate old buildings. Also we feel there should be a study on the food preparation and handling and there are comments on the budget. On page 5 you will see we have discussion and presentation of facts. The No. 1 item - The Loss of Accreditation Status of the Faribault State School and Hospital. The reason we have brought this out is that we feel it is important because the group that decides what hospital is accredited or not has given specific reasons for not accrediting Faribault State School and Hospital. I might also say at this point that I think Dr. Engberg has said that the Ancker State Hospital is the only one at the present time that is accredited and the rest of them also have lost their accredited standing pretty generally for the same reason. The reason that were given by The Joint Commission on Accreditation of Hospitals were these: Inadequate staffing - Overcrowding - The housing of 700 patients in inadequate buildings. We feel, certainly as we have gone through and reviewed the program, these are very important considerations.

SENATOR CHILD: Is there anything in your report as to what would be accepted by the member organizations on accreditation?

MR. WALSH: They have a list of things they would like to see changed. They have not said specifically that there should be so many more people - they have not spelled it out as such. They said that when the institution feels that it might meet the standards they will make another visit.

SENATOR CHILD: What about Owatonna? Is our building program alleviating that situation? How long ago is it since they have had their last meeting?

DR. ENGBERG: In 1958. We had been accredited for many years but the accreditation then had been on the basis of the hospital alone - that is the institution hospital. I am sure that if this accreditation had been on the same basis we would have had it, but now they make it institution wide.

SENATOR CHILD: Do you think if they came to Faribault today and after the changes that have taken place the past two years -

DR. ENGBERG: I don't believe they would.

SENATOR CHILD: Are you as overcrowded now as you were then?

DR. ENGBERG: Approximately yes. I would say not quite to the same extent but still we have areas. We still are understaffed.

MR. WALSH: Turning to page 6 - we go into considerable detail here regarding the inadequate staffing. We feel staffing is a very serious problem

especially as it relates to the psychiatric aides that are taking care of the children. We met with Dr. Cameron and Mr. Hursh of the Department of Welfare and they agree with our findings and they are very well aware of the shortage of staff. We feel it is more acute here than at other institutions for the retarded in the State of Minnesota. One of the problems that we feel exists is that by the time the institution budget gets to the legislature it is not related to the need but is related to the fiscal problem of the State. We recognize that the fiscal problem of the state is not getting enough money to do the job - there is a tremendous tax problem. You will see on the table on page 6 that in 1955 the institution requested 106 positions, the Department of Welfare reduced the previous complement by 11, the legislature allowed 4 fewer than had been allowed before. In 1957 the institution requested 153 positions and received 16, and in 1959 they requested 136 and received 29. Granted that any institution will have some vacant positions at any one given time because of people who have died and left their positions, but nevertheless I do not think that the fact that some of the positions might be vacant can be construed that the institution does not need a considerably larger staff. I am sure that this is the way it is done. We do feel that staffing is a serious problem.

On page 7 - 63 percent of the U. S. Institutions have a lighter patient load for the psychiatric aides, the employees who directly watch over the retarded patients. Faribault very keenly feels the need for more aides. In visiting with the administration and with the aides we realize that their job is very difficult, that because of the shortage of staff they cannot do a job which is satisfactory to them as workers. They feel this very much. We also have the feeling it would be easier to enlist employees, especially psychiatric aides if they were being asked to carry a more reasonable load of work that they are at the present time because of this shortage.

Also 50.7 percent have a lighter patient load for their doctors; 25.7% have a lighter patient load for their nurses; 53% of U. S. institutions have a lighter patient load for their social workers and 71% have a lighter patient load for their psychologists. Now I cite this example - not that California is doing it exactly right, I understand that California is very much in debt as a State - but nevertheless there is an institution in California which is approximately the same size as this one - they have 13 psychologists and we have 1. I think there is 2 allowed in the budget. Certainly California might have more than enough but if there is twice as many as they need, they still have 7 and we only have two.

SENATOR CHILD: May I interrupt - how many psychiatrists were allowed by the Legislature - do you know Dr. Engberg? More than you have been able to fill?

DR. ENGBERG: Do you mean for us here. We have only been able to bring in one psychiatrists and that is Dr. Smith as Clinical Director. We have at the present time two requisitions that we have submitted, one is for a psychiatrist, that has been in now for several weeks and noone has been certified to us for that position and the other for a pediatrician. We feel here with the great number of young children that we are bringing in that we ought to have more attention to the pediatric aspect - someone who is familiar with children's diseases, development, etc. Many of the pediatricians would have a great

deal of psychiatric training. A good deal of it has come into the picture.

SENATOR CHILD: If you could get the psychiatrists right now if they were available - how many would you be authorized to hire?

DR. ENGBERG: Two.

SENATOR CHILD: Do you think that if we raise the salaries of doctors, two, three or four thousand dollars a year, that it would have a material effect on attracting psychiatrists particularly.

DR. ENGBERG: That is a difficult question to answer. It certainly would be helpful, but I think that in connection with professional personnel that salary is not the only thing. I think that one has to think in terms of the program that is in effect, the research, so that all of these things enter into it. If salaries are inadequate, especially in your area, they are going to go to other places unless they have some special reason for wanting to come to a particular institution.

MR. WAJCKE: Would you tell me off hand what the scale is for the psych aides?

DR. SMITH: They start at \$240 as a trainee. They are a trainee for 6 months. They reange from \$260 to \$316.

DR. ENGBERG: I think it is in the professional area that it is a particular serious affair.

MR. WARNKE: In other words this salary scale here corresponds quite favorably with the salary scale outside.

MR. WALSH: It will vary from community to community. Say in Rochester they might have a more difficult time getting aides at this scale than they would at Fergus Falls. I think the comment has been made by people working in this range that if other things were improved, they had a lighter work load and could do a better job the salary would not be a major consideration.

DR. ENGBERG: They put in 8 hours a day. The particular work is so heavy that they just are not equal to standing up under it day after day.

MR. WALSH: The following paragraph taken from a previous report by our Association to the Legislature may give further light on the Faribault staffing problem:

"In this section, the understaffing of the Faribault State School and Hospital will be spotlighted.

"This will be done by the use of a number of tables and comparisons. This approach greatly oversimplifies the problem because the needs of 3,250 patients cannot be neatly reduced to all encompassing numbers and tables.

"Indeed, the inadequate staffing problem at Faribault has been brought about by looking at its needs strictly in terms of numbers. For at least ten years now, Faribault has simply been regarded as a cost unit in the State of Minnesota's total cost picture. It has been receiving its proportionate share of the governmental dollar, not according to its needs, but according to how much it received during the preceding biennium.

"Such a system continues to penalize a facility which has never been adequately provided for. It continues to reward any facility which has been adequately provided for. It doesn't properly adjust to changing times and conditions.

Later I will refer to some of the changing conditions.

"Obviously, neither the Department of Public Welfare, the Governor, nor the legislators have the time or the facilities to scrutinize in detail the needs of the hundreds of individual units which add up to our State Government. It is easy for a facility such as the Faribault State School and Hospital to get lost in the shuffle. Indeed, even the Minnesota Association for Retarded Children should be criticized for not waking up sooner than it has to this staffing problem.

We go on and talk about other considerations. We feel that one problem is that Faribault came into the post war era understaffed and during the war years it was not always possible to fill even the authorized positions. Up through 1957 seven new dormitories housing approximately 700 patients were added. These have not been staffed according to standards established by the Department of Welfare and which now applies to all new buildings added at other institutions. Thus Faribault fell further behind in its staffing needs.

Because of an increasing desire on the part of parents not to institutionalize their children if there is some other more desirable alternative, there are somewhat fewer mildly retarded patients at Faribault than formerly. These are the patients requiring the least attention. Conversely, there are more patients now in attendance who require a great deal of attention.

Now in speaking of this building program and also staffing I think we might look at page 10. We are passing out a new page 10. It was pointed out by Dr. Engberg and Dr. Smith that the figures on the new page 10 should be

No. who are ambulant or partly so and have IQ over 20, and are over 10 years in age:	124	81%
No. who are not ambulant, or have IQ under 20, or are under 10 years in age	28	19%
	152	100%

This makes the figures better. The point here is that Faribault is transferring able ambulant patients needing less care to Brainard and are receiving from the waiting list children who need more care, not ambulatory and the more severely retarded. This is going to increase the need for more staff and likewise it is going to mean that some of the other buildings that should be used for ambulant patients needing little care cannot be used for the non-ambulant patients that need more care.

In recent admissions, as I understand it, the parents of the more severely retarded are choosing to institutionalize their children and parents of more of the less severely retarded are choosing to keep them home - perhaps because of better community facilities. The population of our institutions are changing so we have fewer working patients than we had before and more patients that need more care. I think as we tour the building this afternoon you will see the comparison and realize that the children needing more care could not possibly be in a building like the Colony building, and buildings like this.

Going back to page 8 - The Faribault Building Program. We say that enclosed as Appendix C is the Faribault Building Program recommended by the Faribault administrators. This program has been thoroughly studied by the Association, and we endorse this building program. We wish to emphasize several aspects of it:

- a. The program recommended by the 1961 legislative session should be implemented by the 1961 legislature. We feel that it is important that these recommendations be carried through.
- b. The \$20,000 request for a Building and Site Study is intended to clarify many of the recommendations for subsequent legislatures. Since 1956 the Association and the Faribault administration have taken the position that the building program for Faribault should be related to:
  1. Plans for relieving the overcrowding which exists, mainly in the old, inadequate buildings.
  2. A decision as to what ought to be the patient capacity of Faribault - should it be reduced, should we tear down old buildings. Actually if we reduced the capacity to eliminate the overcrowding we could not tear down the old buildings anyway.

(A discussion was carried on as to transfers - it was pointed out that transfers are shown as transfers and not as new patients.)

MR. WARNKE: What is your patient load now.

DR. ENGBERG: 3300.

MR. WALSH: Going on - in considering the 1961 recommendation, it can be seen that the total requests is for \$3,146,400.00. \$2,000,000 of this request is for two new 125 bed male dormitories. The following is the justification for this request.

With the new Brainerd Institution opening up, patients are being transferred from Faribault to Brainerd. It will be noted that Faribault is transferring a greater percentage of patients requiring a minimum amount of care than it will receive from the waiting list. This is what we said before. We can skip page 10 because we went over this.

Many of the male patients being transferred are from the Grandview, Sunnyside and Colony buildings. These buildings, while inadequate even for the older, ambulatory males cannot be used for the new admission patients from the waiting list since they require a maximum amount of care.

Thus, an immediate and critical need for Faribault is two new, 125 bed dormitory units for male patients. These will, in effect, replace 250 beds in the Grandview, Colony, and Sunnyside buildings. This need is so urgent that it must be done regardless of any long-term plan.

It is further recommended that these new buildings be of the one-story type construction. This is recommended because:

1. The one story building is versatile. Over the years it can accommodate any kind of patient. Thus it can be used for one type this year, another type five years from now. It eliminates the risk of accumulating non-functional buildings.
2. It is ideal for non-ambulatory patients, for wheelchair patients, and for small children. It is also suitable for ambulatory patients. In short, it is suitable for all types of patients.
3. The prototype design, already used in the latest Cambridge buildings, enables an aide to keep track of the maximum number of patients.
4. The design will not adapt to gross overcrowding.
5. The cost is about \$8,500 per bed, or \$1,062,500 per dormitory.
6. The two story, 250 bed dormitory design costs about the same per bed if elevators and ramps are included. The prototype design for such buildings has been used in some of the buildings erected at Rochester and Faribault in the early 1950's.

We also feel that it is very important that money be appropriated to make a study of the Institution and to decide what the future size will be and then to outline a real long term program for the building. We might ask this question - Don't we have a Building Commission? We do certainly. I think that their work is so pressing at each Session that they can look one or two years ahead but they are not able or haven't been able to make architectural studies and develop a long range detailed plan for each institution. This is what we hope could be done at Faribault.

There is brief discussion as to the pros and cons of one and two story buildings.

DR. ENGEBERG: I think it might be well to mention that here we feel that for the first group they could be the one story building. We are going to have this great number of young and helpless types of patients that are coming in, those patients could go into this area and then those patients who are ambulatory and in the two story buildings now will go into the other area that is being opened up because of transfer to Brainard. What the future should be is something that I think is going to require a long range study because if they are to be one story buildings you have to have more ground area. If they are multiple story buildings then you have to think in terms of where they are going to be located and when we have our large unit to be replaced, for instance the custodial building for males and females patients which have dining rooms in them that take care of several buildings, you are going to have the problem of not only the patients in the buildings, but are you going to put dining rooms in those buildings or are you going to build the dining room as the separate building. There are all of these problems that come up. I think it is going to take a good many years before these things can be done and it has to be done in an orderly manner. You have to arrange so that buildings are where present steam lines are and all of those factors come into play. It may depend upon the ground situation, if you have rock near the surface in one place and don't have it in another, it is going to tremendously influence the cost of constructions. All of these things come into play.

MR. WALSH: In 1956 Association members studied the building needs of Faribault and inspected many of the buildings. It was concluded, with agreement from the Faribault administrators, that dormitories housing some 700 patients were badly in need of replacement. It was further concluded that this could be done on a priority basis over a ten year period. We have been negligent in assuming that this plan would be submitted to the Minnesota Legislature. We find no mention of these needs in the Long Term Building Plans now before the (this is according to my previous report) 1959 legislature.

Turning to page 13. We have listed what we felt was the replacement schedule and the importance of them.

Grandview, the one that was mentioned; Three "Colony" buildings; two buildings in the Skinner Hall group; Hillcrest and Sunnyside.

Moving on so that we are finished by noon, we feel that there is a need for a study to determine how food should be prepared and handled here at the Faribault State School and Hospital. The kitchen has had additions made to it here and there. There are approximately 10,500 meals prepared in this kitchen every day. At the present time most of the food is distributed to I believe 20 dining rooms by truck. However a lot of the food distribution is still done by underground system. In 1958 an inspection of the Faribault food system was made by Mr. A. C. Avery and we attached a copy of his report to this report. Mr. Avery, who is a food technician said it was one of the worst that he had observed and he is referring here to the facilities at Faribault to do the job.

Mr. Rolshan has the following impressions which he has put down on paper after many visits to Faribault.

1. That a satisfactory job is being done with the equipment, space and help available.

2. No offensive odors were detected, and a superficial level of cleanliness and sanitation prevailed.
3. Because of innumerable cracks in floors, walls, and equipment, it would appear that adequate protection against insects, rodents, and bacterial contamination would be very difficult to maintain.
4. It is easy to visualize how the material flow in and out of the kitchen area constitutes a major problem. As the institution grew piecemeal, so did the kitchen. When one considers that 10,500 meals per day are prepared in the kitchen, the material handling problems are staggering.

In the author's opinion, a study of the kitchen problems by outside experts is clearly indicated. The study should be directed toward supplying the following information:

1. A detailed plan and cost estimate for modernizing the existing facilities.
2. A detailed plan and cost estimate for building new facilities.

The Association will attempt to estimate how much this study might cost. If it is a modest amount of money, say under \$10,000, steps should be taken to get the money immediately from the Legislative Advisory Committee. We feel this way, that a study could be made now and perhaps some action could be taken by the 1961 legislature to improve this situation.

The balance of the pages are the Appendix and we have attached here the information regarding the hospital accreditation, the Avery report which refers to the food handling, the reports submitted to the Building Interim Commission and also we have various tables on staffing.

The third point is that we would like to suggest specific areas to visit and it may be that Dr. Engberg might have others in mind and it may be that he may not agree with the ones that we suggest, but the plan originally was that we should suggest areas that should be visited by the Commission and these suggestions may be dealt with in any way you see fit.

First we would like to suggest that you visit the kitchen area, the area below the kitchen where the food is handled going through the tunnels.

Secondly we feel that it is important that you visit the Colony Buildings which I understand are the oldest buildings here - there are 3 in the group and one partly burned during the last session of the legislature.

Also I think it important to visit one of the new buildings. These buildings are designed very well and you can compare the buildings.

I also think Chippewa and perhaps Sunnyside - these are my suggestions but Dr. Engberg might have others. It is important that we see in some of the dormitory areas the extent of overcrowding.

DR. ENGBERG: I have some material I wish to hand out.

1. REPORT ON TASK FORCE.
2. PSYCHOLOGICAL SERVICES.
3. PATTERN OF MALE PATIENT MOVEMENTS 1960
4. PATTERN OF FEMALE PATIENT MOVEMENTS 1960

The Report of Task Force was made in November 1959. It is not quite up to date but give essential figures. You will have this to look over at your convenience. Also the Psychological Services. I thought it would be interesting for you to have a copy of the Pattern of Male and Female Patient Movement in 1960. These will explain the movement of patients, how they come to the institution originally and as they move depending on changes either in their age or other conditions.

(Copies of the above have been placed in the members folders.)

MR. WANGENSTEEN: May I bring up one other thing and that is to attempt to emphasize the need for adequate staffing patterns, not only at the hospitals and institutions but in the Central Office and the County Welfare Boards. Mr. Walsh alluded to recommendations that state monies be made available to supplement the staff of the County Welfare Boards who actually do the case work job in the local community.

MR. WALSH: That has been fully discussed.

DR. ENGBERG: Maybe Miss Coakley can give us some information concerning the waiting list. After we make our transfers we will be accepting from the waiting list and for a few years we are going to have a problem that is a rather difficult one to meet adequately and to plan on the basis of what the program should be after we get down to a normal level. I asked Mr. Knack of our school department to be there this afternoon because I thought this was one of the matters that could be mentioned. We have roughly about 200 in the school classes now. There are between 30 and 40 that ought to be in class but we do not have teachers to take care of them. We will be accepting roughly 200 children to replace patients who were not in the school department. How many of those are going to be children who should have something in the way of school we cannot determine. After a period of time we should be taking patients normally from the waiting list as they are committed. It is an entirely different situation than you have now. That is the reason this matter of long range planning is so important and it all ties together. What should be the ultimate final capacity of this institution? Ultimately as the program expands we would be accepting patients from the waiting list at the time of commitment and I think it would be interesting to know what the waiting list is and the type of patients. That is going to influence what our long range plans should be.

MISS COAKLEY: The waiting list at the present time is 1248. The reason I place such emphasis on the current figure and definition of retardation is that I believe in the 1960s we will be seeing a different trend and different focus in the field of mental retardation than what we have been seeing in the past. In pointing out the emphasis on the social and cultural factors

in mental retardation means that we probably, through more skills available for our staff in the community, be able to maintain more and more of these mentally retarded satisfactorily in the community and even help them to function at a better level than we had thought possible in the past. This places a great deal of emphasis on diagnostic procedure. We are very much concerned about that, we are concerned about increasing diagnostic facilities within the community, but this also is terrifically important in terms of institutional staff and our concept and use of institutions. I am afraid that in the past we thought of institutional care for the retarded on a long time basis and now that we realize that more can be accomplished with the retarded, I believe that we can see the institution caring for the severely retarded on a long time basis, but we will see our institutions more treatment and educationally oriented than we have in the past, which comes back to the question of staffing. If we are going to meet the needs of the retarded, we are going to need sufficiently skilled staff within our institutions. This also relates to the discharge rate of the institutions. We are trying to clear this waiting list of 1248, trying to make institutional space available when it is needed and when it is most appropriately planned for the retarded. We would like to have the space available rather than have a family waiting 3 to 5 years as in the past. In order to do this we are screening our waiting list very carefully. This is a responsibility that is being placed upon the counties. We are now asking if institutional care is the most appropriate plan to meet the needs of this child and his family, or are there facilities within your community which can better meet the needs of the individual. This means good diagnostic thinking in the first place, it means re-evaluation from time to time to find out what are the needs of this person at this particular stage of his development. Then also to try to meet the needs of the retarded throughout the State and the retarded within the institutions we should be carefully diagnosing all our retarded within our institutions and being able to return to the community at the most appropriate time those in institutions who can be returned to the community. Because there has not been this focus on diagnostic thinking, because there has not been staff both within the counties and within the institutions, I believe that we do have a backlog of a number of patients within our institutions who could return to the community. If we had sufficient staff within the institutions to work them up on diagnosis, on evaluation of what their potential is and then through our section in the Central Office and with the counties be able to increase our discharge rate. Our discharge rate has been extremely small. As a matter of fact about 126 per year has been going out and this is very, very small. We must step up this discharge rate. This is going to be the focus of our section. As Dr. Engberg and the rest have said, it is true that we are having a changing picture in retardation, that we will be using the institutions for the severely retarded, those coming in will require much more both in terms of care and then for the moderately and mildly retarded they will be requiring more in terms of treatment. With the development of community resources the mildly and moderately retarded who can be in our schools in the community will be remaining there. Let us say that in 1957 there were 3,500 in special classes in the State of Minnesota, but just two years later as the result of the legislation that was passed by the 1959 Session there are 5,000. This is a good jump up in just a two year period. This means people are going to be remaining in the community. Those of the mild

and moderate level of retardation who will be coming to the institutions and are probably going to have associated problems along with mental retardation, which means we are probably going to need more psychiatric services available. We will need more psychological and social workers services in order that we can have the dynamic program so that these people may have the treatment and education or care that they need, then when the condition has changed be returned to the community. The group, of course, that will require custodial care are again where we are going to need our increases in patient aides and staffing, where they will be helpless people, the ones who will not be able to help themselves. So at all levels of retardation I think we are going to see a different kind of programming and different staffing needs. This is why Mr. Wangenstein was bringing up that we cannot approach the building program without approaching program planning and staffing - it all is tied together.

SENATOR CHILD: That 1240 on the waiting list, is that taking into consideration the percentage of those that will decide they do not want to commit their child.

MISS COAKLEY: Not entirely Senator Child. We have been trying to analyze the waiting list and trying to get it down to rock bottom since last fall, and if it had been increasing as we had anticipated, in September it was 1360 and we have had approximately 120 commitments, so you see it would have been much higher. We have already removed a number from the waiting list. We are finding that as we are offering space to fill the available space by transfers to Brainard that we are still getting rejections even on the basis of this analysis, so I think this could be cut down somewhat. We wrote out on all the case on the waiting list starting last Fall - Will you please re-evaluate this situation and determine whether institutional care is the most appropriate plan for this individual rather than the fact that space will be available, it will be offered next year.

MR. WALSH: Parents have changed their minds - this is actually what they want?

MISS COAKLEY: The development of community resources have changed the picture considerably.

SENATOR CHILD: The social workers that are engaged by the welfare board, are they kept quite well coordinated with your problem, is that a part of their training and are they kept up to date on changes of the ramifications of the whole program.

MR. WANGENSTEEN: The best we can with the limited staff. We, of course, have our basic organization calls for what we call Welfare Consultants, representatives who visit the counties periodically every 3 or 4 weeks and this becomes an assignment to them. It is quite well coordinated. We can do better with more staff. We do the best we can with what we have.

MR. REEDLE: Do you know or have you any idea how long it will take to commit that many people?

MISS COAKLEY: Approximately 526 will be admitted during 1960 so you see we will still have a backlog awaiting institutional placement, but here is where we hope through speeding up our discharges we might be able to continue admitting from the waiting list.

MR. WALSH: I am personally not greatly concerned over the fact the waiting list is 1248 as long as there is some provision for emergency commitment. If the child cannot be taken care of either in the home or a boarding home in the community, one of our and Mr. Hursh's recommendations is that we give consideration to aid for the boarding home if the child could be kept there. I don't think the size of the waiting list is the most important fact we are dealing with.

SENATOR CHILDS: How are they admitted?

MISS COAKLEY: The plan up to the present time has been largely on a priority basis in relationship to the date of commitment. However, we have always through the years tried to make immediate space available in any situation where no plan could be made. By no plan I mean we always ask when institutional space is not readily available through the counties, have you developed a boarding home or do you have a boarding home available which will care for this person, is there a private group care facility within the state where this person may be cared for until his name is reached on the waiting list. As top priority we do accept for immediate placement those whom the counties cannot make a plan for in one of the ways I have suggested. Then comes those who are in need of treatment because of a psychiatric problem for whom no appropriate facility is available in the community. The third priority are those who need education which is not available.

There was general discussion as to the meeting date in March, but it was decided that all the subcommittees would meet in March and that there would be a meeting of the whole committee on April 6th, Wednesday, at 10:00 in the State Capitol.

The afternoon was spent touring the Faribault institution, the class rooms, recreational facility, dormitories, etc. Mr. Knack, Principal of the Faribault School, explained a little bit about the school facilities.

Meeting adjourned.

Respectfully submitted,

*Moppy Anderson*  
Moppy Anderson, Secretary.

IW